MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CANCER AND CHRONIC DISEASE CONTROL
SHOW ME HEALTHY MISSOURIANS/SMHW

BREAST DIAGNOSIS AND TREATMENT

P. O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

ENROLLMENT SITE/SATELLITE (NAME AND ADDRESS)	REFERRING PROVIDER (FOR DIRECT BILLING)

A. PERSONAL DATA

NAME (LAST, FIRST, MIDDLE INITIAL)

DATE OF BIRTH	SOCIAL SECURITY NUMBER	CLIENT ELIGIBILTY VERIFIED
____/____/_____ MM DD YYYY	_____–_____–_____	☐ Yes ☐ No

INSURANCE COVERAGE	DEDUCTIBLE MET	REFERRAL FEE	TYPE OF MEDICARE	BCCT
☐ Yes ☐ No	☐ Yes ☐ No	☐	☐ Part A ☐ Part A and B	☐ Yes ☐ No

B. ADDITIONAL BREAST IMAGING

☐ Reporting only

Diagnostic Mammogram ☐ Conventional ☐ Digital _____/_____/_____ MM DD YYYY

Film Comparison _____/_____/_____ MM DD YYYY

Additional Mammographic view(s)

	L	R	
Normal	☐	☐	(1) Negative (Category 1)
	☐	☐	(2) Benign Finding (Category 2)
Abnormal	☐	☐	(3) Probably Benign (Category 3)
	☐	☐	(4) Suspicious Abnormality (Category 4)
	☐	☐	(5) Highly Suggestive of Malignancy (Category 5)

Final Imaging Result

	L	R	
Normal	☐	☐	(1) Negative (Category 1)
	☐	☐	(2) Benign Finding (Category 2)
Abnormal	☐	☐	(3) Probably Benign (Category 3)
	☐	☐	(4) Suspicious Abnormality (Category 4)
	☐	☐	(5) Highly Suggestive of Malignancy (Category 5)

Ultrasound _____/_____/_____ MM DD YYYY ☐ Rescreen ☐ Reporting only

Left: ☐ Complete ☐ Limited
Right: ☐ Complete ☐ Limited

	L	R	
Normal	☐	☐	(1) Negative (Category 1)
	☐	☐	(2) Benign Finding (Category 2)
Abnormal	☐	☐	(3) Probably Benign (Category 3)
	☐	☐	(4) Suspicious Abnormality (Category 4) - Refer to BCCT
	☐	☐	(5) Highly Suggestive of Malignancy (Category 5) - Refer to BCCT
Other	☐	☐	(7) Unsatisfactory - not interpreted - repeat (not paid)

BREAST DIAGNOSTIC PRODEDURES

Specialist Consultation Date _____/_____/_____ MM DD YYYY Diagnostic Work-up Planned ☐ None ☐ 0-60 days ☐ 61-90 days ☐ Reporting only

CBE WNL ☐ Yes ☐ No **(If "No" indicate finding below)**

Benign finding
- ☐ (1) Fibrocystic changes, diffuse lumpiness, clearly defined thickening, or nodularity

Suspicious for cancer
- ☐ (2) Discrete palpable mass
- ☐ (3) Nipple discharge
- ☐ (4) Nipple or areolar scaliness or erythema
- ☐ (5) Skin dimpling, retraction, new nipple inversion, peau d'orange, ulceration; also one breast lower than usual; or unilateral prominent veins, or unilateral increase in size
- ☐ (6) Enlarged, tender, fixed, or hard palpable supraclavicular, infraclavicular, or axillary lymph nodes; also swelling of upper arm

Fine Needle/Cyst Aspiration _____/_____/_____ MM DD YYYY Cytopathology Performed ☐ Yes ☐ No ☐ Reporting only

Left Breast

Type
- ☐ Superficial
- ☐ Deep tissue under guidance

Result
- ☐ (1) Negative
- ☐ (2) Indeterminate
- ☐ (3) Suspicious for Malignancy - Refer to BCCT
- ☐ (4) Malignancy - Refer to BCCT

Right Breast

Type
- ☐ Superficial
- ☐ Deep tissue under guidance

Result
- ☐ (1) Negative
- ☐ (2) Indeterminate
- ☐ (3) Suspicious for Malignancy - Refer to BCCT
- ☐ (4) Malignancy - Refer to BCCT

Biopsy _____/_____/_____ (MM DD YYYY) ☐ Reporting only

Location ☐ Physician Office ☐ Hospital outpatient Facility Fee ☐Yes ☐No Anesthesia ☐

Primary Biopsy Type: Clear

Breast ☐ **Left** ☐ **Right**

Percutaneous
- ☐ Stereotactic Guided (19081)
- ☐ US Guided (19083)
- ☐ Needle Core, No Guidance (19100)

☐ Add Lesion

- ☐ Incisional, No Guidance (19101)
- ☐ Excisional

☐ Mammogram Guided ☐ Stereotactic Guided ☐ US Guided
Preoperative placement of clip? ☐ Yes ☐ No
Radiological exam? ☐ Yes ☐ No

Additional Primary Pathology:
- ☐ No additional pathology
- ☐ 1 additional pathology
- ☐ 2 additional pathology
- ☐ 3 additional pathology

Additional Lesion: Clear

- ☐ Incisional, No Guidance (19101)
- ☐ Excisional

☐ Mammogram Guided ☐ Stereotactic Guided ☐ US Guided
Preoperative placement of clip? ☐ Yes ☐ No
Radiological exam? ☐ Yes ☐ No

Additional Primary Pathology:
- ☐ No additional pathology
- ☐ 1 additional pathology
- ☐ 2 additional pathology
- ☐ 3 additional pathology

Additional Facility Fee ☐ Yes ☐ No

Biopsy Result (Report only most severe result)
- ☐ (1) Benign
- ☐ (2) Benign/Atypical
- ☐ (3) Indeterminate
- ☐ (4) Malignancy

Status of Final Diagnosis
- ☐ (1) Work-up Complete (Complete Section C)
- ☐ (2) Work-up Pending
- ☐ (3) Lost to Follow-up (Enter Lost to Follow-up Date in Final Diagnosis Date)
- ☐ (4) Work-up Refused (Describe in coment section/Must have signed waiver)
- ☐ (9) Irreconcilable (Does not follow typical protocol - Describe)

Next Breast Cancer Screening Date _____/_____ MM/ YYYY

Other Procedure (specify): _____

Other Procedure Date: _____/_____/_____ (MM DD YYYY)

C. BREAST DIAGNOSIS (Diagnostic result with (*) require treatment)

Final Diagnosis
- ☐ (3) Breast Cancer not diagnosed
- ☐ (4) **Lobular Carcinoma In Situ (LCIS)** *(Stage 0)**
- ☐ (5) **Ductal Carcinoma In Situ (DCIS)** *(Stage 0)**
- ☐ (2) **Invasive Breast Cancer***

Final Diagnosis/Imaging Date _____/_____/_____ (MM DD YYYY)

D. BREAST TREATMENT

Status of Treatment
- ☐ (1) Started
- ☐ (2) Pending
- ☐ (3) Lost to F/U (Describe in comment section)
- ☐ (4) Refused (Describe in comment section/Must have signed waiver)
- ☐ (5) Not Needed

Type
- ☐ (1) Surgery
- ☐ (2) Radiation
- ☐ (3) Chemotherapy
- ☐ (4) Hormone
- ☐ (5) Immunotherapy
- ☐ (6) Other Cancer Therapy

Specify _____

Treatment Facility
(Facility Name/City)

Date Treatment Started _____/_____/_____ (MM DD YYYY)

COMMENTS